DENVER SPINE SURGEONS, LLC
7800 E Orchard Rd, Suite 100
Greenwood Village, CO 80111
Phone: 303-697-7463
Fax: 303-783-1200

MEDICAL RECORD & X-RAY RELEASE

PATIENT INFORMATION

_____
Name

_____
Social Security #

_____
Birth Date

RELEASE INFORMATION TO or FROM
(Please circle one)

_____
Name

_____
Address

_____
City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Denver Spine Surgeons, LLC to release/receive my medical records and/or x-ray studies to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Denver Spine Surgeons, LLC and its physicians and staff from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: ( ) Please initial. Specifically authorize the release of the following information:

_____ Alcohol and/or drug abuse, if any

_____ HIV/AIDS status, if any

_____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

_____ Copy of office visits

_____ Copy of hospital History & Physical, Discharge Summary, Operative Notes

_____ Copy of complete chart

_____ Copy of imaging studies

_____ Other: (specify) _____

A copy/fax of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Signature of Patient/Legally Authorized Person Date

_____ _____
Printed Name of Person Authorized to Sign for Patient How Authorized

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FOR PICK-UP OF MEDICAL RECORDS:

_____
Name of person authorized to pick up records for patient (PLEASE PRINT)

I, _____, authorize the above named person to pick up my medical records.

_____Photo I.D Checked Records released by: _____Date:_____